

Femi-Care Surgery Center, LLC

66 Painters Mills Road, Suite 106 • Owings Mills, MD 21117 • Ph: 443 394.0523 • F: 443 394.0524

Patient and Insurance Information

Last Name _____ First Name _____ M.I. _____
Address _____ Address 2 _____
City _____ State _____ Zip Code _____
Date of Birth _____ 19 _____ SSN _____ - _____ - _____
Home Phone (_____) _____ Work Phone (_____) _____
Marital Status (circle one) S M D W Referred by _____
Emergency Contact/Phone _____

PRIMARY INSURANCE COVERAGE

Insurance Co Name _____
Insured _____
Relationship Self Spouse Mother Father
Insured D.O.B. _____
Policy Number _____
Group Number _____
Co-pay Amount _____
Employer _____

SECONDARY INSURANCE COVERAGE

Insurance Co Name _____
Insured _____
Relationship Self Spouse Mother Father
Insured D.O.B. _____
Policy Number _____
Group Number _____
Co-pay Amount _____
Employer _____

I authorize SHEO P. SHARMA, M.D., P.A., F.A.C.O.G. to apply for benefits on my behalf for services rendered by SHEO P. SHARMA, M.D., P.A., F.A.C.O.G. I request payment from my insurance company be made directly to SHEO P. SHARMA, M.D., P.A., F.A.C.O.G. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Signature of Patient/Guardian

Date

